NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

PRIOR AUTHORIZATION REQUEST FOR OUTPATIENT SPECIALIZED THERAPY SERVICES

For an authorization request to be considered, a **SIGNED AND DATED** Physician order, and the most current treatment plan, goals and updated progress summary or notes must be attached. If this is an initial authorization request, also attach evaluation. Include all other applicable documentation to support authorization request.

Initial Authorization Request _____ **Reauthorization Request** _____ _____ _____

Recipient Medicaid ID # _____ **Date of Birth: (MM/DD/YYYY)** _____ **Male:** _____ **Female:** _____

Recipient Name: (As shown on Medicaid card) Last: _____ **First:** _____ **MI** _____

Recipient County of Residence: _____

Parent/Guardian Name (If applicable): _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Billing Provider Name: _____ **Medicaid Group Provider #:** _____

Address: _____ **DEC# (if applicable):** _____

City: _____ **State:** _____ **Zip:** _____

Contact Name: _____ **Phone:** (____)_____ **Fax:** (____)_____

Provider Type (Check Appropriate): IPP _____ **DEC** _____ **HHA** _____ **Other Public Health Agency** _____

MD Services _____ **Hospital Outpatient Clinic** _____ **Area Mental Health Center** _____

Requesting Therapist Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____)_____ **Fax:** (____)_____

Type of therapy request: OT _____ **PT** _____ **ST** _____ **RT** _____ **Audiology** _____

Dates of Service (MM/DD/YYYY) Start	Stop	ICD-9-CM DX Codes (List Treatment First)	Number of Units Requested	Date Requested (MM/DD/YYYY)

Authorized Signature : _____

FAX to Medical Review of North Carolina, Inc. (MRNC) at 1-800-228-1437
For Authorization Request questions, contact MRNC at 1-800-228-3365

Instructions for Completing the Outpatient Specialized Therapies Prior Authorization (PA) Request Form

1. Initial Authorization Request
   Place a check mark on the line to indicate that this is the initial PA request for this recipient for this type of therapy. If this client was previously treated and discharged from therapy services, but it has been over 6 months since the last date of service, place a check mark on this line.
2. Reauthorization Request
   Place a check mark on the line to indicate that this is a PA request for continued services. If this client was previously treated and discharged from therapy services less than 6 months prior to this request, place a check mark on this line. Note: A maximum of 3 reauthorizations may be requested on this form. If more than 3 reauthorizations are required, a new form must be initiated.
3. Recipient Medicaid ID#
   Enter the nine digit and alpha suffix Medicaid number. If a Medicaid number has not been assigned, enter "Pending".
4. Date of Birth
   Enter the recipient's date of birth as a 2 digit month, 2 digit day and 4 digit year.
5. Male/Female
   Place a check mark next to the recipient's gender.
6. Recipient Name
   Enter the recipient's last name, first name and middle initial. If no middle name, enter "NMN".
7. Recipient County of Residence
   Enter the name of the county in which the recipient resides.
8. Parent/Guardian Name
   If the PA request is for a recipient under 18 years of age, or if the recipient is over 18 years of age and has an appointed guardian, enter the parent or guardian's complete name.
9. Mailing Address
   Enter the recipient's complete address.
10. Billing Provider Name
    Enter the complete name of the billing provider.
11. Medicaid Group Provider #
    Enter the 7digit Medicaid group provider number for the billing provider. If the billing provider is not part of a group, enter the billing provider's 7digit individual Medicaid provider number.
12. Address
    Enter the billing provider's complete mailing address.
13. DEC#
    Enter the 7digit DEC provider or referral number, if applicable.
14. Contact Name
    Enter the name of the person to who review correspondence and review questions should be addressed.
15. Phone
    Enter the telephone number, including area code, at which the contact person can be reached.
16. Fax
    Enter the fax number, including area code, to which review correspondence or review questions may be sent to the contact person.
17. Provider Type
    Place a check mark next to the provider type that will be rendering therapy services to the recipient.
18. Requesting Therapist Name
    Enter the complete name of the therapist requesting PA for this recipient. If the requesting therapist name is the same as the billing provider name, enter "Same".
19. Address
    Enter the complete mailing address of the requesting therapist. If the address is the same as the billing provider, enter "Same".
20. Phone/Fax
    Enter the telephone number and fax number, including area codes, of the requesting therapist. If the phone and/or fax numbers are the same as the billing provider, enter "Same".
21. Type of Therapy Request
    Place a check mark next to the type of therapy that is to be provided to the recipient.
22. Dates of Service
    Enter the Start and Stop dates for which PA is being requested, as a 2 digit month, 2 digit day and 4 digit year.
23. ICD-9-CM DX Codes
    Enter the ICD-9-CM diagnosis codes that accurately reflect the recipient's condition/reason for therapy. The diagnosis code(s) reflecting the reason for treatment should be listed first. Diagnosis codes should be entered on **one line** of the table, separated by a comma, **for each PA request**.
24. Number of Units Requested
    Enter the number of units that are being requested.
25. Date Requested
    Enter the date that the PA form was completed, in a 2 digit month, 2 digit day and 4 digit year format.
26. Authorized Signature
    The request for PA must be validated by the individual authorized by the provider to sign the form.